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Setting Priorities in Reproductive Health: Lessons Learned

- *Setting reproductive health priorities is an important component of the health sector reform process as it leads to more efficient use of resources.*
- *Setting priorities requires good information from clinical, epidemiological, financial, and programmatic sources.*
- *Multisectoral stakeholder participation is a key component in determining priorities that can be acted on.*

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Setting Priorities in Reproductive Health: Lessons Learned

"In practice, the implementation of a strategy to achieve [truly comprehensive reproductive health care] will require priority setting, especially given the ongoing, indeed worsening, resource constraints — it is not possible to do everything immediately and to do it all well."

Waddell, 1995

Why Set Priorities?

In 1990, reproductive health conditions accounted for a quarter of the overall disease burden for women of reproductive age in developing countries, ranging from 8 percent in China to 40 percent in sub-Saharan Africa (AbouZahr and Vaughan, 2000). Box 1 lists some of the common reproductive health problems experienced by women. The spread of HIV/AIDS in many areas has magnified these problems (WHO, 1999). The loss of life is significant; the economic consequences are substantial; and the burdens are shared unequally among the rich and poor, and among urban and rural residents.

In response, the 1994 International Conference on Population and Development (ICPD) in Cairo called for comprehensive reproductive health services. Nearly all countries now place at least some policy emphasis on preventing and treating reproductive health problems. UNICEF, the World Bank, UNFPA, and the U.S. Agency for International Development (USAID) are among the many aid and lending institutions that emphasize reproductive health. Nevertheless, the necessary resources, both domestic and international, continue to be scarce. Nowhere in the developing world do reproductive health programs reach all the persons who would benefit. Nowhere do they put into effect all the knowledge and technology that medical science and public health can offer. Nowhere, even in the industrialized countries, is it possible to do everything now. This means that policymakers and program managers must set priorities. Questions to be considered include:

- Which reproductive health services shall be provided now?
- Which reproductive health services later?
- At what level of service?
- Under what circumstances?
- And which reproductive health services not at all?

Sometimes in a Ministry of Health (MOH) or a local clinic, no one ever asks these five questions about priorities. Even when not asked, though, the questions are still answered! At the end of the day, the month, and the year, it must turn out that some treatments have been withheld in favor of others, some services delayed, and some at-risk populations left uncounseled. Indeed, the five questions about priorities are always answered — but not always answered well.

What happens if nobody faces these questions about priorities head-on, if nobody decides explicitly and ahead of time which services to emphasize? Where, then, do the answers come from? Box 2 presents responses from several program managers. Decisions can be influenced by donors, past allocation patterns, and other political, legal, and ethical considerations.

It is evident that resource allocation decisions are not always systematic and may not provide the most value for the money invested. Fortunately, there is a much better way to make decisions: *priority setting*. Priority setting is a natural part of the process of getting things done. Often it takes place after overall goals have been established — for example, after a policy goal has been set to improve reproductive health by devoting a certain amount of resources. Priority setting then determines what will be done first with those resources, what later, and what will not be done at all. Knowing these priorities, program managers can determine specific interventions and operating plans.

Box 1. What are common reproductive health problems affecting women?

- Maternal morbidity and mortality
- Unwanted pregnancy
- Reproductive tract infections/sexually transmitted infections (STIs)
- HIV/AIDS
- Reproductive cancers
- Abortion complications
- Sexual and gender-based violence
- Infertility
- Pre- and post-menopausal care
- Adolescent reproductive health

How to Set Priorities

Priority setting involves a number of steps, inputs, and players. Use of accurate, relevant information and participation of key stakeholders are prerequisites for setting priorities (see Box 3 for examples of reproductive health stakeholders). Figure 1 illustrates the priority-setting process in an effective policy and program context. In practice, priority setting entails a review and revision of existing priorities in order to focus on specific interventions that will improve the reproductive health of the population. The process requires the following information and analyses:

- Assess the disease burden of each reproductive health problem to be considered. The importance of a reproductive health problem increases

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Box 2.
Reflections from program managers: What influences priorities?

- "Donors have significant influence on which activities are pursued. If an activity is not funded by the donors, then it is not done." (Zambia, Malawi, Mozambique)
- "Current expenditures are determined by past allocation patterns." (Thailand)
- "Certain activities are deemed 'necessary,' without knowledge of effectiveness." (Honduras, El Salvador)
- "Other considerations (political, legal, ethical) can override economic considerations in determining overall resource allocation patterns." (South Africa, Cote d'Ivoire)
- "Actual budgets and allocations are somewhat ad hoc." (Nicaragua, Guatemala)
- "No connection between district-level government planning and central funding." (Kenya)

Source: Bollinger and Stover, 2000

with its severity for the affected individual, with the magnitude of the problem in the population, with its relationship with morbidity and mortality from other diseases, and with its contribution to societal hardships and human rights violations.

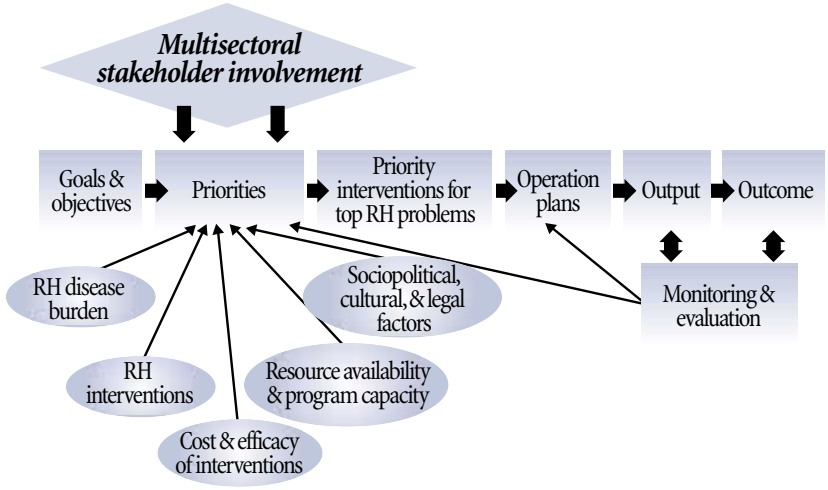
- Consider all reasonable reproductive health interventions or options that can address these problems.
- Gather available clinical, epidemiological, financial, and programmatic information about the options to assess the cost and efficacy of each option. Both international and context-specific information are applicable. Using the clinical and epidemiological information, assess the extent to which each option is capable of ameliorating the reproductive health problem it addresses. Using the financial and programmatic information, assess the *additional* program requirements and costs of each option in light of the facilities, equipment, and personnel that are already in place. Give special consideration to interventions, such as treatment for sexually transmitted infections, that benefit others in addition to those directly receiving the services. No individual can be expected to pay for the public health benefits of his or her treatment to the community at large, so the government must pay at least some of these costs.

  In addition, assess the financial impact of *new* interventions. Consider options that private sector providers are unlikely to finance because they cannot effectively charge clients for these services. Avoid offering free or subsidized services to clients who are already paying for those services.
- Using the financial and programmatic information, assess the resource availability and program capacity to implement and sustain the reproductive health intervention. System capacity is the starting point for all additions, modifications, and elimination of services. Understanding this capacity brings the priority-setting exercise down-to-earth and helps program planners determine which interventions are realistic, e.g. those that can be achieved with existing capacity and those that require viable levels of capacity building versus those that require unattainable increases in financial and human resources.
- Assess favorable or cautionary sociopolitical, cultural, gender, legal,

Box 3.
Reproductive health stakeholders

- Program managers
- Health policymakers
- Professional associations
- Advocacy groups
- Male and female community groups
- Private commercial suppliers
- Religious groups
- Donors
- Male and female representatives of the general public
- NGOs

Figure 1.
Priority Setting in an Effective Policy and Program Context[1]



[1] Priorities are defined as the top reproductive health problems for which alternative interventions are evaluated. Potential interventions are then prioritized by stakeholders on the basis of data collected during the evaluation. Outputs are the results obtained at the program level by carrying out planned activities using program resources. An example of an output measure might be the number of births attended by a trained health worker. Outcomes are the specific results that the program is trying to achieve. An example of an outcome measure might be the percentage decrease in maternal mortality. A program's intended outcomes are related to established goals.

and human rights considerations for each option.

Priority-setting exercises should conform to the particular institutional and policy environment. Priorities can be set at any level — from the program to the region, to the nation, and beyond. Likewise, priorities can be set for a particular activity, such as reproductive health, or across the health sector in its entirety. Ultimately, national governments and international aid organizations may set priorities across a broad spectrum of policy areas. Practical models and techniques are available to help policymakers and program managers set priorities, no matter how narrow or broad their domain of responsibility.

A program planner following the recommended priority-setting processes would expect each option chosen to

- Respond to an important reproductive health problem;
- Have high potential to ameliorate that problem;
- Be realistic within the capacity of the system; to impose low additional program requirements and costs. The possible exception to this rule is the need to build capacity to cope with new or rapidly growing problems such as treatment of opportunistic infections associated with HIV/AIDS;
- Supplement rather than substitute for what the commercial sector is providing and what clients are already paying for themselves;
- Have minimal cultural and related negative consequences; and
- Enjoy widespread support among stakeholders.

The planner would expect that some other option would not be chosen if it responded to the same problem but was found to have the opposite characteristics and effects. In practice, however, the choices among prominent options are rarely so clear-cut. For that reason, the planner may help guide a group of stakeholders in setting priorities for reproductive health by using group decision processes.

How Priority Setting Works in Practice

Models and Techniques for Priority Setting

The available models and techniques for priority setting generally begin with group discussion for identifying reproductive health problems and available options for dealing with them. These models then take the group through a systematic process of priority setting, including the analysis of current information. Although they do it in different ways, the models and techniques all seek to order the decision steps logically so that not every reproductive health condition, and certainly not every possible option, receives the same in-depth appraisal. Table 1 presents different priority-setting models and techniques.

Key Lessons Learned from POLICY Applications

Setting priorities requires good information. Stakeholders will need data and information from clinical, epidemiological, financial, and programmatic sources in order to decide their reproductive health priorities. They will use the clinical and epidemiological information to assess the extent to which each option is capable of ameliorating the reproductive health problem it addresses. They will use the financial and programmatic information to assess the capacity of the reproductive health system to implement and sustain the different interventions, as well as the additional program requirements and costs of each option. Box 4 presents a case study on how the POLICY Project is assisting stakeholders in the use of up-to-date information for setting priorities in Ukraine.

When gathering relevant information for priority setting, both international

Box 4. What information will inform the priority-setting process in Ukraine?

In March 2001, Ukraine approved the National Reproductive Health Program (NRHP), 2001-2005. In order to develop feasible implementation plans for the NRHP, local governments needed to set priorities that would ensure more efficient allocation of resources. This required information about relative costs and impacts, political viability, and the burden of disease.

POLICY assisted the city of Kamianets-Podilsky to establish six reproductive health priority areas by adapting the Columbia Framework to the local context and providing the following information for consideration in the priority-setting exercise:

- *Cost of providing reproductive health interventions:* Estimated the cost of the reproductive health interventions that addressed Kamianets-Podilsky's six priority reproductive health problems.
- *Health system capacity:* Conducted a study of the efficiency of resource use to targeted interventions.
- *Cultural and social factors:* Interviewed stakeholders about major cultural and social factors such as contraceptive preferences and attention to infertility that have an effect on reproductive health service provision.
- *Efficacy of interventions:* Provided international information to assess the efficacy of reproductive health interventions.

The information was collated in a briefing booklet that POLICY then used as the basis for a priority-setting exercise. Using the priorities identified, POLICY assisted the multisectoral group to develop a reproductive health implementation plan.

Table 1.
Models and techniques for setting reproductive health priorities

Columbia Framework	The Columbia Framework helps policymakers and planners choose program priorities from among the many reproductive health problems and potential interventions. The framework suggests a systematic application of six factors in choosing priority interventions of leading reproductive health problems (McGinn et al.,1996). Nepal and Ukraine health officials applied this model collaboratively with The POLICY Project.
Essential Services Package (ESP) Model	The ESP Model is a computer-based tool for measuring impacts, estimating costs, and setting priorities. The POLICY Project, in collaboration with Research Triangle Institute and The Centre for Development and Population Activities, developed this model. The Ministry of Health collaborated with the POLICY Project to apply it to reproductive health programs in Bangladesh (POLICY Project, 2000).
GOALS Model for HIV/AIDS	The GOALS Model supports national strategic planning by linking program goals and funding. It can be used to show how the distribution of funds will affect HIV/AIDS prevalence and coverage. The POLICY Project, in collaboration with Horizons, developed this model and has worked with Ministries of Health to apply it to HIV/AIDS in Lesotho, Cambodia, Kenya, and South Africa (Stover et al., 2001).
Musgrove Model	The Musgrove Model posits nine criteria for deciding public spending on health care and specifies the hierarchical relationships among them. Structuring decision making according to these relationships saves time and effort by eliminating unlikely options early on in the process. This model was developed by the World Bank Institute and is featured in its training (Musgrove, 1999).
Nominal Group Technique	Nominal Group Technique is a highly structured technique that moves from a free-wheeling, option-generating exercise based on individual members' contributions to a priority-setting phase in which each option is assigned to one of four priority categories. This technique was developed in the 1960s and has been used extensively in Total Quality Management for organizational decision making and in the health care field for priority setting (Jones and Hunter, 1999).
Stakeholder Analysis	Stakeholder Analysis is a systematic technique with clearly-defined steps and applications for mapping stakeholders' power, interest, and influence around a particular policy issue. With roots in the political and policy sciences, this technique has found use in health policy and planning (Brugha and Varvasovszky, 2000).

and context-specific information can be introduced. The former can serve, for example, to characterize aspects of a clinic's operation conducted according to widely accepted protocols. The latter will be necessary to describe health system capacity and legal issues in the given country, region, or locality. Particularly in those cases where differences in cost or effectiveness between one intervention and another are likely to be much larger than the variation in cost or effectiveness from one setting to another, international data from other countries will suffice. Information may come from the POLICY Project's *Guide to Effective Evidence-based Reproductive Health and STI/HIV/AIDS Interventions,* scientific studies, procedural protocols, and worldwide and regional databases (Gay et al., 2002). Information on some subjects — cultural issues and legal and human rights, for example — will not be numerical, but are no less important.

In many cases, the reproductive health information that decision makers would like to have will not be available; and when it is available, it may not be of sufficient currency or quality. Nevertheless, policymakers and program planners must set priorities and undertake actions using the best data available. Using what they can obtain, session planners should synthesize the relevant data and other information in a briefing book. Stakeholders should receive and review this material prior to the priority-setting exercise.

Broader participation and consensus contribute to effective implementation. Multisectoral stakeholder participation, for many reasons, is a key component in determining priorities that can be acted on. To begin with, broad representation creates a transparent process that helps build consensus and allows the government to harness the synergies across sectors. In addition, it is important to seek cooperative arrangements with other agencies and ministries, with beneficiaries and community groups, and with the commercial sector, as the government moves its priorities to action. For example, a priority to promote adoptions or to increase economic and social support for pregnant women might well be carried out in cooperation with faith-based organizations. Consumers also set priorities in their revealed preferences for the methods of FP/RH they choose (or ignore), and these priorities can help guide public priority setting. Accordingly, when the focus is on health impact, broad cooperation is essential because these impact indicators respond to various influences in the environment, not

just to reproductive health factors.[2] Box 5 presents a case study of how POLICY is working with stakeholders in Lesotho to assess different resource allocation options.

The priority-setting process should be flexible. The process of health sector reform significantly alters the ways in which reproductive health services are financed and delivered; this, in turn, significantly influences the priority-setting process. In some countries, reproductive health and health sector reform efforts are complementary and compatible. In other countries, there may be conflicts between the goals of health sector reform and those of reproductive health. In such cases, it is preferable to describe certain reproductive health priorities in equity terms, such as satisfying unmet need for contraceptives or providing reproductive health services in poorer and underserved households or for adolescents.

Setting reproductive health priorities is an important component of the health sector reform process as it leads to more efficient use of resources. As a part of health sector reform, many countries have undergone a process of developing ESPs, which specify priority services, cost-effective interventions, and roles of different sectors in delivering and financing chosen interventions.

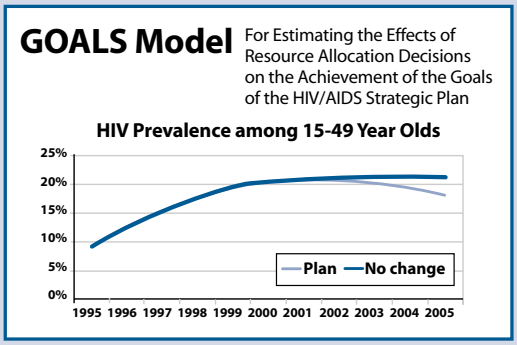
A priority-setting process that takes place at the subnational level is often more responsive to local needs and it facilitates community participation. Greater community participation results in representation of diverse political, ethnic, religious, and cultural groups in decision making. Also, decentralization of decision making exerts a powerful influence on how the organizational unit in question behaves, be it a province, region, district, or hospital/health facility. The POLICY Project's work in Bolivia, presented in Box 6, provides an example of the complex process involved in shifting decision-making control and financial autonomy from the central to the municipal level of government.

Even with priority-setting models, appropriate data, and knowledgeable

[2] Impact indicators identify changes in reproductive health outcomes in the target population that result from program interventions.

Box 5.
How did broad participation influence resource allocation in Lesotho?

Lesotho's National AIDS Strategic Plan (2000/2001-2003/2004) sets goals in the areas of prevalence, incidence, onset of sexual activity, condom use, sexual partnering, counseling, and gender sensitivity, along with programmatic actions to achieve them. The GOALS Model, a resource allocation model customized for the Lesotho case, was used to sort out the most cost-effective means to achieve the best combination of results in these seven goal areas.



The Lesotho AIDS Program Coordination Authority led the multisectoral analysis team, which included members from the Ministry of Development and Planning, Positive Action, Lesotho Anti-AIDS Alliance, and UNAIDS. The POLICY Project provided technical assistance and trained team members in the use of the model and how to adapt it to the Lesotho strategic plan.

The multisectoral Lesotho team used this model to develop alternative budget scenarios and examine the feasibility of achieving the stated goals at lower cost. Analysts assisted government planners in preparing a summary and detailed inventory of funding needs and goals that could be presented to potential donors. The participatory nature of the multisectoral approach resulted in decision makers assigning greater weight to the resource allocation recommendations made by the analysis team than might otherwise have occurred.

Box 6.
A need-based participatory approach at the municipal level in Bolivia: What does a decentralized priority-setting process involve?

The POLICY Project's experience with municipal planning in Bolivia provides an example of priority setting and strategic planning at the decentralized level. In the mid-1990s, the government of Bolivia passed two groundbreaking laws that laid the foundation for transferring decision making and financial control to local governments and gave citizens the right to participate in local governance.

With assistance from POLICY, 11 municipalities set forth to translate the law into action. POLICY conducted three-day participatory planning workshops that were attended by more than 450 women and men representing civil society organizations, indigenous groups, women's groups, youth groups, and local governments. The workshops began with a discussion of the laws. Participants then used data on the health, education, and economic status of their municipality to identify problems and their causes; identify strategies to address these problems; and set priorities among the strategies on the basis of financial, political, and cultural viability.

Many of the workshop participants subsequently participated in the municipal planning process and brought to the table the participatory, information-based, priority-setting techniques they had used in the workshops. As a result, the priorities in the Municipal Development Plans of these target municipalities included, for the first time, programs and funding for sexual and reproductive health, an issue that was identified as a priority during the workshops.

stakeholder participants, priorities — once established — are not meaningful and relevant forever. As progress is made in one area of reproductive health or as infectious diseases spread in another area, the relative importance of the different conditions will change. Research may introduce new medicines and procedures. Other government departments or the commercial sector may change their own activities in ways that affect current interventions. New laws may emerge. Even if nothing else changes, a new group of stakeholders may bring changing societal values into the priority-setting process.

Except in the most quickly changing situations, such as the rapid spread of HIV/AIDS, a fresh priority-setting exercise every five years should suffice. More frequent priority shifts, if they are taken as seriously as they ought to be, can disrupt policy and program progress more than they can contribute to it. Less frequent assessments will allow the priorities to drift slowly into irrelevance.

Setting priorities is never easy: challenges and complications abound. When setting out to engage in meaningful priority-setting exercises, be prepared to confront a number of objections and challenges. For example, these might include statements such as the following:

- Purposeful priority setting takes time and energy away from getting going and doing the job.
- International donors often have their own priorities that always prevail — so why waste time?
- We are powerless to change events and have to take what is offered because of scarce resources and bureaucratic constraints.

These objections and challenges must be addressed successfully in order to achieve stakeholder buy-in for the process.

Even if the process succeeds, priorities that will be accepted by both health professionals who have to implement them and the public affected by them can often involve painful decisions. Painful because funds and skilled staff for high-priority programs usually must come from de-emphasizing some other reproductive health program or from some other area within or outside the health sector. For example, in Nepal, even though its priority-setting workshop generated a lot of interest among stakeholders, the mechanism of following through with the priorities was not given due attention (see Box 7).

The case in developing country environments for explicit priority setting in reproductive health is strong. The process works, as shown in the example from Jamaica presented in Box 8. While the available models and data all have limitations, these are far outweighed by the advantages of clear assumptions, open deliberations, and continuing buy-in by stakeholder participants. There is also the possibility that the priority-setting process or its results will draw entirely new resources from public or private sources, domestic or international. In fact, the only parties who should oppose participatory priority setting are the most vocal special interest groups and "turf protectors" who are accustomed to getting their own way.

One important note of caution: If, indeed, there is a powerful entity — an international donor, a national ministry, or the local program director — whose own priorities cannot be influenced, no matter what emerges from a participatory process, consider whether to take this route. Few endeavors are as disillusioning as those that take time and generate enthusiasm but cannot possibly make a difference. Even, or perhaps especially in this circumstance,

Box 7.
Identification of reproductive health priorities in Nepal: Why is follow-through important?

In 1996, Nepal developed a National Reproductive Health Strategy (NPRS), which reflected the broad objectives of the ICPD *Programme of Action*. However, it was not until 1998 that the Family Health Division (FHD) of the Department of Health Services (DoHS) in Nepal initiated a process of setting priorities for the public sector provision of reproductive health services.

The FHD selected the Columbia Framework to structure data collection and the priority-setting process. For the six reproductive health problems and each of the 23 interventions identified, a local research organization collected information. This information was compiled as a briefing book.

With assistance from POLICY, approximately 50 representatives of the MOH, other line ministries, donors, NGOs, and the private commercial sector met for two days to develop reproductive health priorities. The focus of discussion was the NRHS, the briefing book, and the expertise individual participants brought to the table.

The workshop ended with the final statement of the priorities consolidated in a Trend Matrix. However, the priorities identified were not entirely consistent with those of the major donors. Because donor priorities were not given as much weight as perhaps was necessary, funding for follow-on activities in some priority areas has been unavailable. This has resulted in slow progress in those areas. Even with this constraint, the priority-setting exercise generated significant successes. A core group of stakeholders was identified to develop an action plan to implement these priorities. The DoHS also agreed to strengthen planning for reproductive health interventions placed in the second group of priorities through additional research and technical reinforcement. The DoHS undertook a national Adolescent Health Survey to better design the adolescent health programs. Lastly, the workshop provided an opportunity for a broad range of stakeholders to contribute to the government's priorities for reproductive health services. The national workshop was a major step in the long-term process of determining national priorities for sexual and reproductive health services in Nepal.

attention must still be paid to building and maintaining stakeholders' buy-in. Certainly, the priorities of donors and governments are part of the information to be made available to participants in a priority-setting exercise. Ideally, these will be only a part of the context, not all that matters.

Wrapping Up

Setting priorities for reproductive health is possible in a developing country environment. And not only possible, but also particularly worthwhile when change is underway and resources are scarce. The resulting stakeholder involvement can itself be more than worth the effort. A data-based operational plan adds to the value. Altogether, by moving resources from cost-ineffective interventions to cost-effective ones, the potential gains for reproductive health can be enormous. Beyond this, a successful priority-setting activity might persuade decision makers to increase the total resources available. For example, broadened policy dialogue and involvement of public and private sectors in both financing and delivery of priority services enable the system to increase the total resources available for priority services.

It is almost always worthwhile to follow a systematic process to set priorities.[3] Even if the process is not as data-intensive as some of the illustrated country examples, engaging a broad range of stakeholders in discussing and debating priorities may pave the way for more effective use of available resources. Fortunately, available tools and assistance put such reproductive health priority setting within the reach of all. ◆

[3] A possible exception to this rule is the presence of a powerful entity whose priorities cannot be influenced.

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Box 8.
Adaptation of national priorities at the local level in Jamaica: What happens when the process works?

The process of strategic planning for reproductive health in Jamaica illustrates the strength of a decentralized approach to priority setting. In response to the 1994 ICPD, Jamaica's MOH prepared a *Strategic Framework for Reproductive Health within the Family Health Programme, 2000-2005*, in collaboration with key stakeholder groups. The framework brings reproductive health components together into an integrated plan to guide central, regional, and parish strategies.

With assistance from POLICY, the framework was disseminated to Jamaica's 14 parishes through workshops in each of the four regions. The workshops were designed to ensure that workplans at the decentralized level were consistent with the framework, reflected local priorities, and that the plans were developed in a participatory manner.

As a result of the strategic planning workshops, the Western and Southern Region Health Authorities have prepared annual program plans with their parishes that integrate the goals, activities, and indicators from the strategic framework. The other regions are developing similar plans. The integration of national policy into local plans is expected to lead to more consistent programming across parishes and better reproductive health for Jamaicans.

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